Legal Assistance Resource Center
❖ of Connecticut, Inc. ❖

44 Capitol Avenue, Suite 301 ❖ Hartford, CT 06106-1764
(860) 278-5688 ❖ FAX (860) 278-2957

Testimony before the Insurance and Real Estate Committee
in opposition to Raised Bill 6382
by Jane McNichol, Executive Director
February 14, 2013

I am Jane McNichol, Executive Director of the Legal Assistance Resource Center of Connecticut, the advocacy and support center for legal services programs in the state. We represent the interests of very low income residents of the state.

I am here to express **opposition to RB 6382, An Act Concerning the Eligibility to Purchase a Health Benefit Plan Offered by the Connecticut Health Insurance Exchange.**

The purpose of this bill appears to be to require that individuals with incomes between 133% and 200% of the federal poverty level, from $15,281 to $22,980, obtain health coverage through the Health Insurance Exchange. The bill also removes the authority of the Exchange to evaluate the feasibility of a basic health program option.

In 2014, the Exchange will be the only option for subsidized health care available to individuals at these low income levels. But by 2015, the federal government will have developed guidance on the State Basic Health Program (SBHP) option in the Affordable Care Act.

The SBHP option was designed to provide a mechanism for high-cost states such as Connecticut to provide affordable health care to adults with incomes between 133% and 200% of the federal poverty level. This provision was included in federal law because of concern that the cost of participation in the Exchange, even with subsidies, would be prohibitive to low-income residents of high-cost states.

After considerable discussion of this option last session, the Office of Health Reform and Innovation set up a **Basic Health Plan Work Group** to make recommendations on whether the State Basic Health Program should be adopted in Connecticut. The Work Group worked over the summer with significant help from the Office of Policy and Management and research by the Milliman consulting firm.

By November, it was clear that the needed guidance from the federal government would not be available in time to implement a State Basic Health Program in January of 2014. The Group adopted recommendations, a copy of which is attached to this testimony, to defer a final decision about a State Basic Health Program until federal guidance was available.

The Group also recommended that the Exchange collect information about the experience of individuals with incomes between 133% and 200% of the federal poverty level in the Exchange to inform a decision about the adoption of a Basic Health Program in 2015.

Rather than removing the authority of the Exchange to evaluate the Basic Health Program option, as this bill does, this **Committee should consider amplifying the language in CGS 38a-1083(c)(17) to mandate that the Exchange collect the data specified in the Basic Health Plan Work Group recommendations.** This will provide us with necessary information as we consider the Basic Health Program option in light of federal guidance.

Jeannette B. DeJesús
SPECIAL ADVISOR TO THE GOVERNOR
OFFICE OF HEALTH REFORM & INNOVATION
STATE OF CONNECTICUT

Basic Health Plan Work Group

Recommendation to the Office of Health Reform & Innovation and the Department of Social Services

December 17, 2012

Over the past nine months, the Basic Health Plan Work Group (Work Group) has explored the Basic Health Plan (BHP) option in the Patient Protection and Affordable Care Act and its implications for residents and the state of Connecticut. We are committed to providing affordable, quality health care coverage to individuals with incomes between 133% and 200% of the federal poverty level. The Work Group developed a set of guiding principles for its analysis and recommendation regarding a BHP. The principles are:

A. Equity
   1. Do no harm. The plan should make no individual or group worse off than they are now. Policy decisions should not disrupt people's lives.
   2. The plan should not require lower income individuals to subsidize costs for higher income individuals.

B. Access
   1. Care and services under the BHP should be available at least to the same extent that such care and services are available to the general population in the geographic area.
   2. The program design should promote access to high quality, comprehensive care and continuity of care.
   3. Payment methods should promote value (high quality at an efficient cost) rather than volume.

C. Sustainability
   1. The plan should be sustainable and financially sound.
   2. The plan should require no additional state funding.
   3. The plan should include design features to reduce the risk of cost overruns.
   4. The plan should maximize federal revenue.

Due to the uncertainties outlined in reports and analyses by Milliman and the University of Massachusetts, as well as the lack of federal guidance and other information needed to make a

decision about whether to proceed with a Basic Health Plan in Connecticut, **we propose that the decision on whether to adopt a Basic Health Plan be deferred until there is further information available to evaluate the costs and benefits of a Basic Health Plan.**

We recommend that the Work Group reconvene within 30 days of the issuance of formal guidance from the federal government on a BHP to consider whether to adopt a BHP in light of the federal guidance.

We further recommend that the Health Insurance Exchange Board of Directors ask its staff to:

- Develop mechanisms for tracking data needed to inform a decision about the best way to provide coverage for the population eligible to participate in a BHP.
- Report quarterly to the Committees on Public Health and Human Services of the General Assembly, and the members of the Work Group, beginning on March 31, 2014 on:
    - Number of individuals in households with incomes between 138% and 150% of the federal poverty level (FPL) enrolled in Qualified Health Plans at any time since January 1, 2014.
    - Number of individuals in households with incomes between 150% and 200% FPL enrolled in Qualified Health Plans at any time since January 1, 2014.
    - Number of individuals in the target income populations continuously enrolled for the calendar year (CY)
    - Number of individuals in the target income populations who enroll in Qualified Health Plans and subsequently (a) become eligible for Medicaid or (b) have income over 200% FPL
    - Number of individuals in the target income populations enrolled at the end of the CY (This number would only be reported at the end of the CY.)
    - The cost of the second lowest priced Silver Premium Plan in the Exchange
    - Number of individuals in the target income populations who experienced gaps in coverage
    - Health care services accessed by these individuals
    - Costs of providing health care services to these individuals and
    - Costs to the individuals of accessing health care through the Exchange
    - Other information determined to be needed to evaluate the cost and benefits of a BHP.
- At the end of CY 2014, conduct a survey of individuals in the target income groups who lost coverage, other than coverage in Medicaid, obtained through the Exchange during the 2014 CY. The purpose of the survey is to determine the reasons for loss of coverage.

Finally, we recommend that the Work Group be reconvened, by the Office of Health Reform & Innovation or the Office of the Lieutenant Governor, no later than January 31, 2015, and review the costs and benefits of a BHP in light of the experience of individuals in the target income group in the Exchange and of federal guidance, if available, and make a recommendation to the Governor and the Committees on Public Health and Human Services on whether Connecticut should establish a BHP.

The Milliman actuarial report and other documents related to the analysis of the BHP can be found on the Work Group's page on the Office of Health Reform & Innovation website.